Amy B. Farnsworth, D.M.D, P.S.C

ORTHODONIST

Brace Yourself for a Fabulous Smile!

2700 Bardstown Road
Louisville, KY 40205
(502) 452-2116
www.farnsworthortho.com

Welcome ~ Thank you for selecting us

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions please ask us and we will be happy to help.

Patient Information (Confidential)

Date: _____

Patient's Name _____
Last First Middle Nickname

Address _____
Street City State Zip

Home Phone _____ Patient's Age _____ Birthdate _____ Sex M F

If student, name of school/college _____ Hobbies _____

Whom may we thank for recommending you to our office? _____

Is another family member a patient at this office? ☐ Yes ☐ No If yes, their name _____

Patient's Dentist _____ Date of last visit _____

Responsible Party* Information

Name of person responsible for this account _____
Last First Middle

Relationship to patient _____ Social Security # _____ Birthdate _____

Address _____
Street City State Zip

Check Appropriate Box: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Name of Bank _____

Spouse's Name _____ Relationship to patient _____
Last First Middle

Social Security # _____ Birthdate _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

*Note: The "Responsible Party" is the individual who will be making payments. If there is more than one "Responsible Party" (ie a divorce case) the parent who signs the contract is ultimately responsible for making the payments.

Dental Insurance Information

Do you have Orthodontic coverage? ☐ Yes ☐ No

INSURED'S NAME _____

NAME OF EMPLOYER _____ Name of Ins. Co. _____

Social Security # _____ Birthdate _____

Ins. Co. Phone # _____

Appointment Information

Providing us your e-mail and/or cell number allows you to receive e-mail reminders or text messages about upcoming appointments and office announcements. A simple registration email will be sent to you to activate this service.

E-mail address: _____ Cell # _____

HEALTH HISTORY

CIRCLE

Does patient have any current health problems? . . . . . Yes☐ No☐

Does patient have any developmental or learning disability? . . . . . Yes☐ No☐

Has patient reached puberty? Girls — Menstruation Age ____ Boys — Voice Change Age ____ . . . . . Yes☐ No☐

Does patient have any history of major illness? If so, describe . . . . . Yes☐ No☐

Physician's Name _____ Phone _____

Has patient taken any medicine or drugs during the past two years? . . . . . Yes☐ No☐

If yes, please list: _____

Is patient now taking any medication, drugs/pills or is patient pregnant? . . . . . Yes☐ No☐

If yes, please list: _____

Are you aware of patient being allergic to or having ever reacted adversely to any medication or substance? . . . Yes☐ No☐

If so, what? _____

*Please circle any of the following the patient had or has at present.

Heart Trouble	Tuberculosis	Hepatitis A (infectious)
Angina Pectoris	Asthma	Hepatitis B (serum)
High Blood Pressure	Hay Fever	Liver Disease
Heart Murmur	Sinus Trouble	Yellow Jaundice
Rheumatic Fever	Allergies or Hives	Blood Transfusion
Congenital Heart Lesions	Diabetes	Drug Addiction
Scarlet Fever	Thyroid Disease	Hemophilia
Artificial Heart Valve	X–ray or Cobalt Treatment	Venereal Disease (Syphilis, Gonorrhea)
Heart Pacemaker	Chemotherapy (Cancer, Leukemia)	Cold Sores
Heart Surgery	Arthritis	Epilepsy or Seizures
Artificial Joints (Hip, Knee)	Rheumatism	Fainting or Dizzy Spells
Anemia	Cortisone Medicine	Nervousness
Stroke	Glaucoma	Psychiatric Treatment
Kidney Trouble	Pain in Jaw Joints	Sickle Cell Disease
Ulcers	A.I.D.S.	Bruise Easily
Cosmetic Surgery	Adenoids Removed, What age? ____	Osteoporosis, Rx ____
Endocrine Disorders	Tonsils Removed, What age? ____	Emphysema

• DENTAL HISTORY •

Have there been any injuries to the face, mouth or teeth? Yes☐ No☐ Describe _____

Has the patient ever sucked a thumb or fingers? Yes☐ No☐ Until what age? _____

Does the patient have any speech problems? Yes☐ No☐

Is patient a mouth breather? While sleeping? Yes☐ No☐ While Awake? Yes☐ No☐

Have you ever been informed of any missing or extra permanent teeth? Yes☐ No☐

Has an orthodontist been consulted previously? Yes☐ No☐

Has patient had any previous orthodontic treatment? Yes☐ No☐

Has patient ever had any TMJ (Jaw Joint) problems? Yes☐ No☐

What are you or your dentist most concerned about? Purpose of this visit _____

Does patient require pre–medication prior to dental cleanings? Yes☐ No☐

NOTICE OF PRIVACY PRACTICES:

I, _____ have received a copy of this office's notice of Privacy Practices.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with *(Name of Patient)* _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I understand that where appropriate, credit bureau reports may be obtained.

Patient: _____ Date _____ Doctor Signature _____ Date _____

if over 18 years old

Parent or Responsible Party _____ Relationship to Patient _____